Clements Family Chiropractic

Wellness For Children & Adults

(586) 781-4314

www.Clementschiro.com

Case Number ______________

Today's Date ______________

Tell Us About You

Title:________ First:____________________ MI:__________ Last:______________________________

Nickname:________ Birth date:__________ Age:________ Sex: ❒ Male ❒ Female

Current address:____

City:____________________ State:____________ Zip:_________ SS #:________-____________-____________

Cell Phone:__________-____________-____________ Work Phone:________-________-_________ Ext:________

Home Phone:________-_________-____________

Email:______________________________ Preferred contact: ❒ Home ❒ Work ❒ Cell ❒ Email

Whom may we thank for referring you?____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____________________________

# of children:_____________ Ages of children:____

❒ Full-time employment ❒ Part-time employment ❒ Unemployed ❒ Retired

Occupation:_________________________ Employer:______________________________________

Student: ❒ No ❒ Full-time ❒ Part-time School name:________________________________

Alternate address:____

City:____________________________ State:___________ Zip:________ Parents/Other:________________

Emergency Contact:_____________________________________ Phone:_________-__________-____________

Emergency contact is your: ❒ Spouse/partner ❒ Parent ❒ Other:_______________________________

Tell Us Why your Here

What is the primary reason for your visit?____

____

Is this due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case ❒ None

When did your pain/symptoms begin (include date if possible)?______________________________

The overall severity of your complaints/concerns is:

❒ Mild ❒ Mild to moderate ❒ Moderate ❒ Moderately severe ❒ Severe

The overall frequency is: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ NA

Are your symptoms/pain getting: ❒ Better ❒ Worse ❒ Staying the same

Have you had a recent treatment for this condition? ❒ No ❒ Yes—please list dates and doctors:

____

Have you had the same or similar problems in the past? ❒ No ❒ Yes—When:______________________

Do you have any additional complaints/concerns/health problems? ❒ No ❒ Yes—please describe:

____

____

Use the following key to mark your complaints on the diagram at the right:

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **O**	Stiffness = **X**	Swelling = **S**
Burning = **B**	Tingling = **T**	

LEFT RIGHT RIGHT LEFT

If your complaints include pain, how would you describe it? (please check all that apply):

❒ Aching ❒ Burning ❒ Dull ❒ Sharp ❒ Shooting

❒ Stabbing ❒ Throbbing ❒ Other:____________________

Since your symptoms began, have you noticed any function changes: ❒ Bowel ❒ Bladder ❒ Sexual ❒ No Changes

Do work activities aggravate your present complaints?

❒ Yes ❒ No ❒ NA

Please mark whether you NOW HAVE(❍) or had IN THE PAST(❒) any of the following conditions/illnesses:

NOW HAVE	IN THE PAST	NOW HAVE	IN THE PAST	NOW HAVE	IN THE PAST
❍	❒Allergies	❍	❒Difficulty Speaking	❍	❒Menstrual Problems or Pain
❍	❒Hay Fever	❍	❒Sinus Trouble	❍	❒Prostate Trouble
❍	❒Fatigue or Weakness	❍	❒Asthma	❍	❒Erectile Dysfunction
❍	❒Night Sweats	❍	❒Wheezing	❍	❒Fertility Problems
❍	❒Unexpected Weight Change	❍	❒Chronic Cough	❍	❒Excessive Thirst
❍	❒Jaw Pain/TMJ	❍	❒Shortness of Breath	❍	❒Thyroid Trouble
❍	❒Sleeping Problems	❍	❒Chest Pain or Pressure	❍	❒Anxiety or Nervousness
❍	❒Skin Problems	❍	❒Heart Trouble	❍	❒Mood Swings or Irritability
❍	❒Loss of Balance	❍	❒High Blood Pressure	❍	❒Mental or Emotional Difficulty
❍	❒Dizziness or Lightheadedness	❍	❒Low Blood Pressure	❍	❒Depression
❍	❒Vertigo	❍	❒Cold Hands or Feet	❍	❒Arthritis
❍	❒Fainting	❍	❒Abdominal Pain	❍	❒Bone Fracture
❍	❒Headaches	❍	❒Indigestion / Upset Stomach	❍	❒Dislocated Joints
❍	❒Seizures	❍	❒Excess Gas	❍	❒Autoimmune Disease
❍	❒Loss of Memory	❍	❒Heartburn	❍	❒Cancer
❍	❒Vision Trouble	❍	❒Constipation	❍	❒Diabetes
❍	❒Hearing Trouble	❍	❒Diarrhea	❍	❒Fibromyalgia
❍	❒Ear Infections	❍	❒Nausea or Vomiting	❍	❒Multiple Sclerosis
❍	❒Ringing or Buzzing in Ears	❍	❒Bedwetting	❍	❒Rheumatic Fever
❍	❒Loss of Smell	❍	❒Urinary Pain or Frequency	❍	❒Tuberculosis
❍	❒Loss of Taste	❍	❒Kidney or Bladder Trouble	❍	❒Other:______________
❍	❒Difficulty Swallowing	❍	❒Blood in Urine or Stool	❍	❒**No Conditions/Illnesses**

Your Activities of Daily Living and Work

Please indicate which activities of daily living are compromised by your current state of health:

❒ Walking
❒ Sitting
❒ Climbing stairs
❒ Chewing
❒ Kneeling
❒ Sleeping
❒ Standing
❒ Lifting children
❒ Reading
❒ Playing instrument
❒ Using telephone
❒ Running
❒ Bending
❒ Laying in bed
❒ Using computer
❒ Exercising
❒ Sitting in recliner
❒ Sports
❒ Swimming
❒ Recreational activities
❒ Getting into/out of an automobile
❒ Driving a car
❒ Riding in a car
❒ Other travel
❒ Sewing or crafts
❒ Doing laundry
❒ Making beds
❒ Vacuuming
❒ Washing dishes
❒ Ironing
❒ Carrying groceries
❒ Caring for pets
❒ Cooking
❒ Mowing lawn
❒ Raking leaves
❒ Gardening
❒ Shoveling snow
❒ Combing hair
❒ Shaving
❒ In/out of bathtub
❒ Brushing teeth
❒ ________________
❒ ________________
❒ None apply

How often does your job involve lifting? ❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Other job requirements (please check all that apply): ❒ Bending ❒ Carrying ❒ Stooping ❒ Twisting ❒ Turning ❒ Walking ❒ Other:____________________

What is your primary work position? ❒ Seated ❒ Standing ❒ Other:____________________

Sickness, Injury and Accident History (please include dates and descriptions)

Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury):____________________

____

____

____

Prior illnesses (other than colds and flu):____________________

____

____

____

Surgeries and hospitalizations:____________________

____

____

____

Are you currently taking ANY over-the-counter medication: ❒ No ❒ Yes—list name and for what condition.

Are you currently taking ANY prescription medication: ❒ No ❒ Yes—list name and for what condition.

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.

DRUG	CONDITION	DRUG	CONDITION

Your Lifestyle

Which is your dominant hand: ❒ Left ❒ Right ❒ Ambidextrous

Which of the following best describes your stress level: ❒ None ❒ Minimal ❒ Moderate ❒ Extreme

Do you smoke? ❒ No ❒ Yes—How much:______________________________

Do you exercise? ❒ No ❒ Yes—How often:______________________________

How many caffeinated drinks do you consume:____________ per day

How many alcoholic drinks do you consume:____________ per week

Do you have weight issues? ❒ No ❒ Yes

Are you currently taking any vitamins or nutritional supplements: ❒ No ❒ Yes—please indicate which one/s:

____

Are you interested in a nutritional evaluation? ❒ No ❒ Yes

WOMEN ONLY: To your knowledge are you pregnant? ❒ No ❒ Yes—Due date:______________

Other Health Care Providers

Have you ever been to a doctor of chiropractic before? ❒ No ❒ Yes—How long ago?______________

Name of previous chiropractor:______________________________

City:______________________State:______________

Do you see a medical doctor or osteopath?❒ No ❒ Yes—Date of last visit:______________

Name of medical doctor:______________________________

City:______________________State:______________

Communication is Key to a Positive Relationship

Is there anything else you would like us to know?❒ No ❒ Yes—______________________________

____

____

____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform Clements Family Chiropractic of any changes in my health status.

Signature:______________________ Date:______________Case:______________